



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELITE HELATHCARE FORT WORTH
PO BOX 1353
FRISCO TX 75034

Respondent Name

TEXAS BUILDERS INSURANCE CO

Carrier's Austin Representative

Box Number 01

MFDR Tracking Number

M4-14-0724-01

MFDR Date Received

October 31, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Office visits are recommended as determined to be medically necessary. Medical necessity for office visits in conjunction with work status form 73... Therefore, these claim should be paid in full."

Amount in Dispute: \$131.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 request was placed in the insurance carrier representative box assigned to JT Parker & Associates LLC on November 7, 2013. Jackie Winans signed for and picked up the DWC060 on November 7, 2013. A findings a decision will therefore be issued based on the information contained in the dispute at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 30, 2013	99080-73	\$15.00	\$15.00
May 30, 2013	99213	\$116.39	\$0.00
TOTAL		\$131.39	\$15.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out the general instructions for Medical Dispute Resolution.
2. 28 Texas Administrative Code §133.308 sets out the procedure for independent review of medical necessity disputes.
3. 28 Texas Administrative Code §129.5 sets out the procedures for completing Work Status Reports.
4. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

5. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 216 – Based on the findings of a review organization
- 193 – Original payment decision maintained

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Did the requestor submit documentation to support the billing of CPT code 99080-73?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."
2. 28 Texas Administrative Code §133.307(f)(3)(B) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General).
The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution for CPT code 99213-25. As a result, the requestor has failed to support that CPT code 99213-25 is eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute for CPT code 99213-25, as a result, no amount is ordered for CPT code 99213-25.

3. Per 28 Texas Administrative Code §129.5 "(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

Review of the submitted documentation finds that the requestor submitted documentation to support the billing of the DWC73 rendered on May 30, 2013, as a result, the requestor is entitled to reimbursement in the amount of \$15.00.

4. The requestor is therefore entitled to reimbursement for CPT code 99080-73 rendered on May 30, 2013.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$15.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §§ 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 16, 2014 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).